South West LHIN

South West Local Health Integration Network
Annual Report 2016-17

Ontario
South West Local Health Integration Network

Contents

Preface 3
Message from Andrew Chunilall, Acting Board Chair and Michael Barrett, CEO 4
Board of Directors 6
The South West LHIN 7
Population profile 9
Community engagement 13
Integrated Health Service Plan 2016-19 17
Integration activities 18
Update on South West LHIN initiatives 21
- Strengthening primary care 21
- Health Links 22
- Emergency wait times and alternate level of care pressures 22
- Home and community services investments that better support seniors and other Ontarians 23
- Hospice palliative care 24
- Mental health and addiction services 25
- eHealth 26
- Health System Funding Reform 28
- Wait times for surgical and diagnostic imaging procedures 30
- Diabetes program update 32

Local Health System Performance 33
Operational Performance 40

Preface

As crown agencies responsible for planning, integration and funding of health service providers in the health care system, Local Health Integration Networks (LHINs) continue to strive towards ensuring health care dollars are spent efficiently and effectively. A commitment to improving the care received by our communities with a triple aim focus on outcomes, experience and sustainability leads their decision-making processes.

LHINs operate within an accountability framework comprised of the *Local Health System Integration Act*, the Memorandum of Understanding between the Minister of Health and Long-Term Care and the South West LHIN, as well as the Ministry-LHIN Accountability Agreement.

As part of this accountability, LHINs are required to submit an Annual Report to the Ministry of Health and Long-Term Care detailing achievements and work being undertaken in the previous fiscal year. This report includes specific requirements outlined in the key framework documents, as well as audited financial statements for the agency.

This Annual Report outlines progress and achievements in the 2016/17 fiscal year. The Ministry of Health and Long-Term Care is required to table the LHIN Annual Report within 60 days of receipt. Once the Annual Report 2016/17 is tabled by the Minister, it can be released publicly.

Message from Andrew Chunilall, Acting Board Chair and Michael Barrett, Chief Executive Officer

We continue to see the tremendous efforts being made by our system partners to improve the lives of the patients they serve. We also know that there are system gaps that we must address to improve the patient experience and deliver high-quality care.

We believe that we need to continue to evolve our health care system so that it better meets the needs of our patients, clients and residents. This report describes key actions the South West LHIN, in partnership with its health system partners, took in 2016/17 to improve health services for all residents of our LHIN.

This past fiscal year, the Ontario government passed the *Patients First Act* to improve access to health care services by implementing system-level changes to allow for faster and better access to care. The Act aims to put patients and their families at the centre of a truly integrated system.

The South West LHIN would like to acknowledge the feedback, advice and guidance we received this last year from partners, key system champions, staff at both the South West Community Care Access Centre (CCAC) and the South West LHIN, and the public. A key step in positioning ourselves for success in implementing the Patients First Act was leveraging the expertise of system champions in our region.

Over the last year we established the Executive Advisory Panel to help provide advice and counsel around the implementation of Patients First. We confirmed our five sub-region areas, Grey Bruce, Huron Perth, London Middlesex, Elgin and Oxford and worked to finalize the groups and committees that will support Patients First.

This past fiscal year also marked the first year of the LHIN's Integrated Health Service Plan for 2016-19. This plan identifies key strategies, outcomes required and priority populations that all organizations, sectors and networks will need to consider in their strategic and operational plans to collectively advance health system improvement in the South West LHIN.

Each three-year strategic plan builds on the accomplishments of previous plans and brings us closer to achieving the LHIN's vision for quality care, improved health and better value. In 2016/17, we continued to implement initiatives focused on achieving our vision, including:

- The continuation of improved outcomes for people with stroke as a result of our stroke realignment work. More people are accessing care through specialized units delivered by practitioners with recognized stroke expertise.

- Considerable progress has been made with the integration of peer support programs in Huron Perth, Oxford and Grey Bruce where partners are working closely together to strengthen the delivery of peer support programs to better support more clients while offering better access to peer support such as expanded hours and services.

- The development of a Primary Care Capacity Report with five recommendations and 65

supporting actions to address barriers people are facing in accessing health care. In the coming months and even years we will be working with health system partners on taking a joint role in solutions and actions around these recommendations.

- The expansion of residential hospice capacity, and continued planning to bring unified solutions to each of the five sub-regions of the LHIN, which will mean more support to palliative patients and their families. This work is key to ensuring that a range of supports are available to enable individuals to die in their place of choice.

- And finally, we have been focused on the implementation of the *Patients First Act*. Over the past year, we have been working alongside the South West CCAC to prepare for the transfer of home and community care staff and functions to the South West LHIN.

As part of achieving our vision, we remain committed to engaging with communities across our region to inform the work of the South West LHIN.

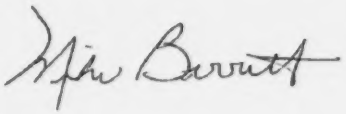
The LHIN has long recognized that listening to patients and their families, and hearing their stories, can lead to improvements within the health system. The LHIN has adopted Health Quality Ontario's patient engagement framework to guide the patient engagement strategy for the South West LHIN. A focus for our upcoming fiscal year will then be to co-design a broader strategy that will help strengthen the patient voice for all of our work. As part of this work, we will continue to take steps to ensure that all residents have access to the same quality of health care regardless of their socio-economic or cultural background, this includes Indigenous communities. We will be increasing the focus on cultural safety and the delivery of health care services to Indigenous peoples and French speaking people in Ontario.

The South West LHIN Board meets regularly with health service provider governors and our communities to promote integration, service coordination and quality improvement. We also continue to build our online relationships with valued partners and community members using digital media social tools to foster dialogue, transparency and accountability.

In working with system partners, including the Ministry of Health and Long-Term Care and health service providers, we remain committed to improving health care delivery for residents within the South West LHIN, as well as throughout the province.

We look forward to strengthening our mission, articulating a vision for the newly integrated organization, and leveraging our collective expertise as we evolve into a more integrated health system in Ontario.

Andrew Chunilall, Acting Board Chair, South West LHIN



Michael Barrett, CEO, South West LHIN

Board of Directors

As of March 31, 2017

Lori Van Opstal (Tillsonburg)
Board Chair
Nov. 6, 2013 - Nov. 5, 2019

Andrew Chunilall (London)
April 11, 2013 - April 9, 2019

Wilf Riecker (Port Stanley)
Nov. 6, 2013 - Nov. 5, 2019

Leslie Showers (St Marys)
Interim Vice Chair
Apr. 20, 2016 - Apr 19, 2019

Myrna Fisk (London)
Nov. 16, 2016 - Nov. 15, 2019

Barb West-Bartley (Wiarton)
April 18, 2011 – April 17, 2017

Jean-Marc Boisvenue (London)
Mar. 1, 2017 - Apr. 31, 2020

Glenn Forrest (London)
Nov. 2, 2016 - Nov. 1, 2019

Aniko Varpalotai (Southwold)
Oct. 3, 2012 - Oct. 2, 2018

The South West LHIN

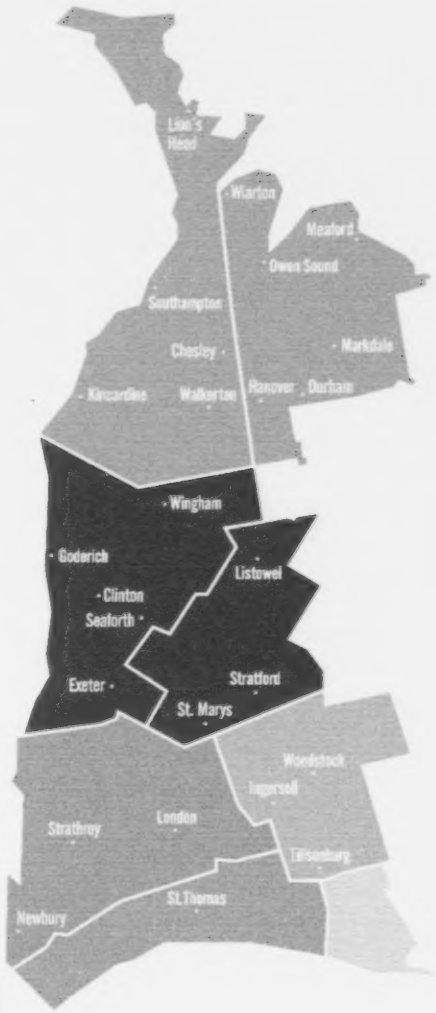
The South West LHIN's work is focused on the planning, integration and funding of over 150 health service providers including: hospitals, long-term care homes, mental health and addictions service agencies, community support services, and community health centres.

Established in 2005, the South West LHIN's region extends from the Bruce Peninsula in the North to Lake Erie in the South, and is made up of both rural and urban communities. LHINs work with providers and communities to determine health care priorities and services required in local communities, reflecting the reality that a community's health needs and priorities are best understood by those familiar with the community.

Together with our system partners, we are ready and well-positioned to continue our efforts to improve health care in the South West LHIN.

To help guide our continued work, all LHINs produce a three-year plan for the local health system that describes our vision, priorities, strategies and proposed outcomes. The plan, called the Integrated Health Service Plan (IHSP), will help us to continue enhancing the health system to better meet the needs of our patients, clients and residents across our geography.

For the vast majority of people who require health care support, they receive it in their home or community. Whether it is in-home care from a personal support worker, nurse or other health care professional, mental health and addictions support, or an adult day program for individuals with dementia, community services are the key to the future sustainability of the health system. They allow for earlier discharge from hospitals,



prevent re-admissions, and help delay or avoid admission to long-term care homes.

Hospitals in the LHIN provide care for those whose needs are beyond the services of a general practitioner, and our long-term care homes are there for those who can no longer live independently in their homes.

The following LHIN-funded organizations play a critical role in delivering services to South West LHIN residents:

- 78 long-term care homes
- 52 agencies providing community support services
- 32 agencies providing mental health and addiction services
- 20 hospital corporations across 33 sites
- 14 agencies providing assisted living/supportive housing services
- 5 Community Health Centres

There are also a number of organizations and professionals that, while they are not funded by the LHIN, play a crucial role in the delivery of health care services for individuals and their families including residential hospices, family health teams, family health organizations, family health networks, solo-physician offices, public health units, emergency health services and labs. While these services do not have direct accountability to the LHIN, it is essential to work closely with them to achieve our vision as an organization.

Population profile

Understanding the South West LHIN's population demographics and health status as well as the ability of the health system to meet population needs, plays a key role in improving population health, experience of care and ensuring value for money.

As part of developing each IHSP, the 14 LHINs work with the Health Analytics Branch of the Ministry of Health and Long Term Care to create a detailed summary of demographic, population health and health system indicators for all LHINs. Unless otherwise indicated, the information below was taken from the provincial environmental scan used to develop the LHIN's Integration Health Service Plan for 2016-19.

The South West LHIN is home to over 957,500 people, or 7 per cent of Ontario's population.[1] The population is predominantly urban, with 50 per cent of residents living in large urban centres, and an additional 20 per cent living within a 30-minute drive from an urban centre, known as the urban commute zone. The remaining 30 per cent live in rural communities.

In 2015, seniors accounted for just over 18 per cent of the LHIN's population, compared to 16 per cent in 2010. The LHIN continues to have a higher proportion of adults aged 65 years or older compared to the provincial average (16 per cent). By 2025, 24 per cent of the South West population is projected to be made up of seniors aged 65 years and older.

Between 2015 and 2020 the number of residents across the South West LHIN is projected to grow by 2.9 per cent, as compared to 5.3 per cent across the province. The South West LHIN is expected to continue experiencing slower than average population growth over the next 10 years for all age groups.

In 2011, approximately 86 per cent of the LHIN's population reported English as their first language. While 14 per cent of the LHIN's population were immigrants in 2011, fewer than 2 per cent were recent immigrants (arriving in Canada between 2006 and 2011).

According to the 2011 Census, approximately 86 per cent of the South West LHIN population reported English as their first language. Francophones accounted for 1.3 per cent of the population. The City of London is currently home to an estimated 8,000 Francophones.

There are five First Nations communities in this LHIN: Chippewas of the Thames First Nation, Munsee-Delaware Nation, Oneida Nation of the Thames, Saugeen First Nation and Chippewas of Nawash Unceded First Nation. The South West LHIN region is located on the traditional territory of the Anishnaabeg. This region has also become the home to the Haudenosaunee and Lenni-Lenape Nations. The LHIN recognizes that the demographic data on Indigenous populations is limited as Indigenous communities tend to be underrepresented in census data.[2] With this in mind, people who identify as Indigenous (First Nation, Inuit and Metis) account for 2 per cent of the LHIN population, with significant

[1] Ontario Ministry of Finance, LHIN Population Projections 2015.

[2] "Census data limitations for Aboriginal populations include: Undercounting (homeless and mobility), non-participation is common (lack of trust), on-reserve enumeration is incomplete, weakened platform for self-identification (long form to voluntary NHS), data suppression, aggregate data, no data for children." Well Living House - Indigenous population health data collection, management, analysis and use, 2015

numbers living in urban and rural communities across the region. There are several Indigenous health services including the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) with three locations, and two Friendship Centres.

In 2011, 8 per cent of residents in the South West LHIN identified themselves as belonging to a visible minority group and 14 per cent of residents were born outside of Canada. Over course of the previous year, communities located across the South West LHIN have welcomed a significant influx of recent immigrants. This influx of Canadian newcomers is not accounted for in the LHIN's census profile.

Socioeconomic characteristics

The median household income in the South West LHIN is $60,037, with 14 per cent of the total population living under the after-tax low-income measure. Education levels are below the Ontario average.

Population income profile	South West	Ontario
Unemployment rate (age 15+)	7.6%	8.3%
Education attained (age 25-64): Population with no certificate/degree/diploma	13.2%	11.0%
Population with completed post-secondary education	59.4%	64.8%
Population living below the after-tax low-income measure [3]	14.0%	13.9%

2011 Canada Census Canadian Community Health Survey LHINS Sharefile (CCHS), 2014/15

General health

Asking people what they think about their own health is an important way to monitor health status at the population level, in part because it has been shown to be an accurate predictor of the actual health, future disability, and life expectancy of a population.[3] Six out of 10 residents in the South West LHIN say they have very good or excellent health, and seven out of 10 reported very good or excellent mental health.[4]

Population Health Status

The health status of residents in the South West LHIN is largely comparable to the Ontario population. A total of 40 per cent of the adult population in the South West has one or more chronic conditions (compared to 37 per cent in Ontario), 56 per cent are overweight or obese (52 per cent in Ontario), 20 per cent are daily or occasional smokers (19 per cent in Ontario) and 49 per cent are physically

[3] DeSalvo, K.B., et al., Mortality Prediction with a Single General Self-Rated Health Question. Journal of General Internal medicine,2006.21: p.267–275.

[4] Idler, E.L. and S.V.Kasl, Self-ratings of health: Do they also predict change in functional ability? The Journals of Gerontology Series B: Psychological Sciences and Social Sciences. 1995.50B (6): p. S344-53.

inactive (49 per cent in Ontario).[5] Prevalence rates of select chronic conditions in the South West LHIN are presented below. The South West LHIN has the second highest prevalence rate of asthma in Ontario, 9 per cent of the population 12 and older, based on self-report; and 5 per cent of the population has chronic obstructive pulmonary disease. Despite their relatively low prevalence, these two chronic respiratory conditions accounted for approximately 12 per cent of all chronic disease-related hospitalizations and 7 per cent of mortality in the South West LHIN in 2013/14.[6] The LHIN also has significantly higher rates of arthritis. The prevalence of arthritis, asthma, diabetes and chronic obstructive pulmonary disease have all increased across the South West LHIN since 2009/10.

Prevalence of chronic conditions in the South West LHIN *Rate per 100 people, 2013 (age 12+)*	South West	Ontario
Arthritis (age 14+)	20.6%	17.3%
Asthma	9.0%	7.5%
Cancer	1.0%	1.9%
Chronic obstructive pulmonary disease (age 35+)	4.8%	4.3%
Diabetes	7.0%	6.6%
High blood pressure	17.5%	18.3%
Heart disease	4.7%	4.8%
Have chronic condition	39.0%	37.3%

Canadian Community Health Survey LHINS Sharefile, 2013/14

Life expectancy

People living within the South West LHIN have a lower life expectancy at birth and at age 65 compared to Ontario.[7] Ischemic heart disease, dementia and Alzheimer's disease, lung cancer, cerebrovascular diseases (stroke), and chronic lower respiratory diseases (pneumonia, chronic obstructive pulmonary disease) are the leading causes of death for residents.[8]

Accessing primary care

There are over 620 primary care physicians actively practicing in community settings in the South West LHIN. Eight nurse practitioners provide additional primary care capacity working in two Nurse-Practitioner-Led Clinics. Fifty-three per cent of the regions' primary care physicians practice as part of the 90 team-based practices (e.g. family health networks, family health organizations, etc.) located within the LHIN. There are five LHIN-funded community health centres: Central Community Centre (St. Thomas), London InterCommunity Health Centre (London), Southwest Ontario Aboriginal Health Access Centre (London and Chippewa), West Elgin Community Health Centre, Woodstock and Area Health Centre. The five community health centres are expected to serve 19,556 residents, or 2 per cent of the total population. A total of 96 per cent of LHIN residents report having access to a regular medical doctor or nurse practitioner.

---

[5] Canadian Community Health Survey LHINS Sharefile (CCHS), 2014/15.

[6] Vital Statistics Registry 2011, Ontario Ministry of Health and Long Term Care.

[7] Table 102-4307 Life expectancy, at birth and at age 65, by sex, three-year average, Canada, provinces, territories, health regions and peer groups, occasional (2007-2009), Statistics Canada,

[8] Vital Statistics Registry 2011, Ontario Ministry of Health and Long Term Care.

Health Care Connect is a service that allows people to find a family physician. Between its launch in February 2009 and December 2016, 51,931 residents have registered with the program and around 90 per cent have been referred to a primary care provider.[9]

In 2016, the total number of primary care physicians actively practicing in community settings increased by 3 per cent. Physicians were successfully recruited into high-needs communities located in Grey, Bruce and Elgin counties. Recruitment is underway to secure additional primary care resources in Grey Bruce, rural Oxford and South London-Middlesex.

[9] Health Care Connects monthly report to the LHIN, June 2015

Community engagement

The Communications and Community Engagement plan for 2016/17 outlined how the LHIN would achieve its communications objectives and priorities for the fiscal year. It considered all audiences and guided the development of all communications plans and activities throughout the year.

Communications and community engagement form a vital public service where the LHIN has a duty to provide information and listen to the public it serves. This outreach contributes to building a system that better understands, listens and meets the needs of patients, clients and residents in the LHIN.

The LHIN used a variety of strategies to inform, consult, involve and collaborate with stakeholders so that communities continue to be engaged on the actions that the LHIN, in partnership with health service providers, is taking to enhance health care delivery for all residents of our LHIN.

The South West LHIN Communications and Community Engagement Plan, as well as the Integrated Health Service Plan for 2016-19 and the Annual Business Plan guided our engagement approach.

Throughout 2016/17, we were involved in a broad range of engagement activities including:

- regularly scheduled advisory committee meetings
- regular meetings with area provider tables
- sector and network meetings
- project and program-specific meetings
- Quality Advisory Group
- the Clinical Quality Table
- the annual Quality Symposium
- physician engagements
- local health and information networking sessions
- engagement with Francophone and Indigenous communities

Quality Symposium

The annual Quality Symposium was held on June 2, 2016 in Stratford, Ontario. The event was attended by 432 people representing a broad range of sectors.

The theme was "Hearing the patient's voice." Presenters included Patient Advisor Judith John, syndicated columnist Andrew Coyne, former Ontario Minister of Health and Long-Term Care George Smitherman, and Health Quality Ontario CEO Dr. Jeffrey Turnbull.

Quality Awards were handed out to two local projects to recognize sustainable and ongoing quality improvement initiatives:

- The Model for Seamless, Integrated Community Support (ONE Care): Collaborating for Client-Centered Care received the award for the small/medium size quality improvement project.
- Access to Care: Assisted Living, supportive housing and adult day program received the award for the large scale quality improvement project.

Physician engagements

In fall 2016, the South West LHIN invited family physicians and nurse practitioners to attend five primary care provider forums to give feedback to the LHIN about the changes in the *Patients First Act*, as well as how to be successful in implementing changes. The LHIN will be using the advice and recommendations from the forums to help develop strong clinical leadership both at the LHIN and sub-

region levels. More than 160 physicians and primary health care providers met across our five sub-region areas to participate in dialogue and discussion.

Local health and information networking sessions

In 2016/17, the LHIN held sessions in Parkhill (April 2016), Port Elgin (June 2016) Flesherton (September 2016), Listowel (November 2016), and Tavistock (February 2017). These sessions were open to governors, partners and the public as a way to foster engagement, information sharing and networking opportunities.

Long-Term Care Home network forum

On September 28, 2016, the South West Long-Term Care Homes Network Council in partnership with the South West LHIN brought together 70 long-term care home providers for its annual Long-Term Care Home Network Forum. The event featured speakers from the Ministry of Labour, Dykeman and O'Brien Health Law, London Health Sciences Centre, and long-term care providers from across the South West region.

Engagement with French populations

Throughout 2016/17, the LHIN participated in several community engagement and planning initiatives to better understand and address challenges for Francophones in the South West LHIN. The South West LHIN Board also welcomed a Francophone member, Jean-Marc Boisvenue, in March 2017.

Regular meetings with the French Language Health Planning Entity continued to advance a joint action plan and collaborative work for community engagement activities. The Entity has also been working alongside the LHIN in recruiting Francophone representatives for the various new committees that LHIN will be involved in as a result of the Patients First Act.

The South West LHIN French Language Services Coordinator continued to actively participate in many French language-focused committees, working groups, and in the planning of the following community engagement events:

- Continued community engagement with the Francophone Seniors Group, Mental Health and Addictions Advisory Group, Table Franco Info and the Entity.
- Developing Francophone patient experience videos in collaboration with the Entity.
- Active participation in the new French Mental Health and Addictions System Network Table, and the South West Mental Health Coalition.
- Active participation in the Community Support Services Network Collaborative.
- Efforts continue to introduce and distribute the French language services toolkit to health service providers, and other system partners in our region to support the implementation of French-language services.
- A French language services information and resources booth was set up in collaboration with the SouthWesthealthline.ca, London Intercommunity Health Centre and the Addiction Services of Thames Valley.
- Helped to plan a Francophone Seniors Fair in spring 2016 and reached almost 200 Francophone seniors.
- Planned health promotion activities including a mental health and addictions webinar, falls prevention, exercise classes, and diabetes education.

Indigenous community engagement

The South West LHIN recognizes that from a population health and equity perspective Indigenous health

engagement planning is a priority area of focus, leading to improvements in health outcomes. For this reason, and consistent with our legislative obligation, engaging with Indigenous communities so that we can co-create strategies to improve health outcomes and patient experience is a priority focus across the LHIN.

Each LHIN works with local Indigenous communities and partners to develop appropriate mechanisms for achieving ongoing and meaningful engagement. It is through these mechanisms, and by working with Indigenous organizations and leadership, that LHINs can create and develop a unique plan for implementing strategies and services to improve Indigenous health across our region.

The South West LHIN in partnership with local First Nations, Inuit and Métis communities to facilitate engagement about the healthcare system and advance culturally-appropriate services, contributing to better patient experiences, enhanced quality of care and improvements in health outcomes for Indigenous peoples in Ontario.

The LHIN role is to develop direct relationships with Indigenous and First Nation communities to:

- Better understand local needs, priorities and opportunities;
- Develop local Indigenous engagement and strategic plans;
- Facilitate relationships across the healthcare sectors;
- Build a base of knowledge that includes better data, traditional approaches to healing and wellness, values, principles and priorities of Indigenous peoples and their families; and
- Develop a framework for action to advance culturally appropriate, accessible, and equitable health care services.

Ongoing and purposeful engagement occurs in a variety of ways to understand the current state and the Indigenous patient experience. Engagement with Indigenous peoples at the patient and family level is best led by the Indigenous community. The LHIN follows ethics and protocols designed to allow those who participate to continue to own, control, access, and protect the knowledge they have shared. Any information that is collected must be used and shared respectfully and appropriately.

In 2016/17 work began on restructuring the South West Aboriginal Health Committee in partnership with Indigenous communities to align with the future new groups that will support the Patient First Act. Through collaboration with the Aboriginal Health Committee members, LHIN staff are working to determine how to enhance and align the existing committee structure to support Patients First.

The Aboriginal Health Lead has provided leadership and support to Indigenous stakeholders and the LHIN in engagement and planning activities:

- Enabling Indigenous populations to be included in the LHIN's work to implement the Patients First Act both regionally and provincially, including: restructuring and enhancing the Aboriginal Health Committee; developing an Indigenous Roadmap; and developing a collaborative leads model.
- Established the Indigenous Clinical Front Line Expert Advisory Panel and developed a charter and work plan to guide the Panel's work. The work plan includes developing an Indigenous hospice palliative care coordination model and an Indigenous Coordinated Care Planning process.
- Evolving and strengthening the focus on Indigenous Cultural Safety

(ICS) and health equity locally and provincially. In 2016/17, 642 health care providers have received the training in the South West LHIN. The goal of the training is to develop and promote individual competencies and positive partnerships with Indigenous patients, families and communities.

- In November, 2016, the Ministry announced $3 million to expand and roll out the ICS program provincially. The South West LHIN, with SOAHAC, who has been designated as the provincial lead, has supported this expansion.
- Presentations to build awareness of the training as an enabler in health equity including: Health Quality Ontario, the Pan-LHIN Health Equity Network, Provincial Indigenous Health Equity Forum, National Indigenous Health Conference, Western University, Fanshawe College and health service providers throughout the LHIN.
- Developed a comprehensive integrated project management document with SOAHAC for the enhanced provincial program.
- Advancing care pathways that have been informed by Indigenous populations for Health Links, primary care and hospice palliative care, as well as enabling a quality improvement approach.
- Facilitated collaboration to build relationships with Indigenous and non-Indigenous stakeholders to foster system improvement.
- Provincial work to strengthen Indigenous engagement mechanisms in Ontario to enable more effective and integrated planning within LHINs.

Partnerships are key to providing better care for the patients, clients and residents served across the South West LHIN. To do this well, LHINs must evolve while collaborating with all partners to move patient-focused local health care priorities forward.

To help guide this evolution, all LHINs produce a three-year plan for the local health system. The plan, called an Integrated Health Service Plan, outlines the key strategies, outcomes required and priority populations that all organizations, sectors and networks will need to consider in their strategic and operational plans to collectively advance health system changes for the South West LHIN.

To advance the priorities and strategic directions of the LHIN's vision, it will be important to pursue population health, experience of care and value for money.

A population health approach focuses on improving the health status of an entire population. The IHSP focuses its strategies and priorities to address specific populations whose needs are greatest. Strategies that improve the health of those with the greatest needs are equally effective in improving overall population health, experience of care and value for money.

As care needs become increasingly complex for some individuals with conditions such as mental illness, addictions issues, advanced age, Alzheimer's disease, diabetes, obesity, and multiple chronic illnesses, the health care system and community partners must focus on supporting these individuals to improve health outcomes and experience of care.

The LHIN will focus on the following priorities for 2016-19:

- Ensuring primary health care is strengthened and linked with the broader health care system
- Optimizing the health of people and caregivers living at home, in long-term care and in other community settings
- Supporting people in preventing and managing chronic conditions
- Strengthening mental health and addiction services and their relationship with other partners
- Ensuring timely access to hospital-based care at the LHIN-wide, multi-community, and local level
- Enabling a rehabilitative approach across the care continuum
- Putting people with life-limiting illnesses and their families at the centre of hospice palliative care

To succeed in transforming the health care system all health service providers and communities must be open to innovative and structural changes to the health system. Embedding the following key strategies will be crucial to achieving the system-level vision we are working towards:

- Health equity
- Integration and collaboration
- Quality improvement and innovation
- eHealth and technology
- Accountability and transparency

The Integrated Health Service Plan helps provide direction to health system partners to deliver quality care, improved health and better value. This plan is intentional about change and takes a structured approach to show our current state as well as where we would like to be in the future. Through a shared commitment to change, this plan will help improve the health of LHIN residents.

Integration activities

LHIN initiatives result in improved coordination of health services that benefit patients and families across the LHIN. Integration activities may not always come forward as formal integrations and are captured elsewhere in the Annual Report. Formal integration activities that progressed in 2016/17 are listed here.

Access to Care: Complex Continuing Care/rehabilitation bed realignment

As part of the Access to Care strategy to help people move out of acute care and into other care settings as quickly, smoothly and safely as possible, the Complex Continuing Care (CCC)/ Rehabilitation (rehab) bed realignment will ensure that these valuable services are provided consistently and equitably across the LHIN.

Huron Perth Healthcare Alliance - Vision 2013

Vision 2013 is a multifaceted plan created to ensure a sustainable health care system in Huron Perth. While implementation is mostly complete, some bed redistribution is set to occur as part of the CCC/Rehab realignment work. This redistribution of beds will shift the number of medical and surgical beds to result in a net decrease of 17 beds. This realignment will better position resources to meet the existing needs in this region.

Vision 2013 has resulted in:

- Consolidated adult outpatient physiotherapy from four sites to two sites completed in 2012 (Seaforth and Clinton sites)
- An interprofessional practice model of care
- Consolidated cataract surgery in the hospital's Clinton site

London enhanced crisis services - Mental Health and Addictions Crisis Centre

Since 2012, community partners have been working together to develop a comprehensive community-based crisis service which has resulted in:

- a 24/7 crisis mobile response program;
- a crisis assessment team;
- rapid response transitional case management support for mental health and addictions and those at risk of homelessness; and
- the London Middlesex Mental Health and Addictions Crisis Centre, which includes 24/7 crisis stabilization beds.

The London Police Services have been partners since 2012 and protocols exist between the London Police Services and the mobile crisis response team. The mobile crisis response team helps police clear calls in a more timely fashion (approximately three hours sooner) and is being used in 70-90 per cent of eligible calls. This work has also helped to divert patients from the emergency department to more appropriate care settings for clients needing mental health and addictions support.

Building on the successful relationship with police, partners are looking to expand protocols to the Middlesex-London Emergency Medical Services. Work on this initiative will continue in 2017/18.

The Crisis Centre partially opened in December 2015, with a full launch in January 2016. In 2016 the Centre had:

- 4,148 visits

- 3,668 walk-ins with an average of 10 walk-ins a day and 480 follow-ups
- 751 individuals utilized the five stabilization beds

Palliative care integration

There are patients in acute palliative care beds whose needs would be better met outside of acute care. Realignment planning of current palliative care beds and resources from an acute setting at London Health Sciences Centre to a non-acute setting at St. Joseph's Health Care London, Parkwood Institute was underway in 2016/17. The future renovation will create 18 single rooms in a home or hospice-like environment overlooking the grounds at Parkwood Institute. This creates more privacy and a much more respectful, peaceful, patient-centred environment for patients and families.

Mental health and addictions coordinated access

Mental health and addiction providers in Oxford, Elgin and Middlesex Counties are working to implement a coordinated access model to better support clients. To date, monitoring and quality improvement measures have been put into place, and there is potential to expand in the coming fiscal year.

In 2016/17, Reach Out, a 24/7 bilingual support line for mental health and addictions issues was launched. Reach Out offers callers crisis support, friendly listening, information and education, or an appointment with a mental health and addictions professional. Families, caregivers, and health care providers are also encouraged to use the line to learn about resources for loved ones or clients. As of February 28, 2017, 7,097 contacts were made, which is a monthly average of 1,150 contacts.

Mental health and addictions peer support

The LHIN began working with the leadership and governance of consumer survivor initiatives/peer support programs and mental health and addiction providers in December 2015 to enhance peer support, through integration within each sub-region (Grey Bruce, Huron Perth, London Middlesex, Oxford and Elgin). A peer support model for the South West LHIN was agreed to by both peer support and mental health and addiction providers in September 2016. Following agreement on the model, work began within each sub-region to identify integration opportunities between peer support and lead mental health and addiction providers, building on the strengths of the existing peer support programs.

Integrating peer support programs into lead mental health and addiction organizations in each sub-region will improve access to services and provide a better experience for clients with mental health and addiction concerns.

Grey Bruce Mental health and addictions

CMHA Grey Bruce, HopeGreyBruce Mental Health and Addiction Services (HopeGreyBruce), G&B House and Grey Bruce Health Services (GBHS) have been working since 2015 to find ways to align more closely and collaborate to better care for the people they serve. Through a series of facilitated governance meetings in 2016, the partners have agreed to a governance and operational integration process resulting in a single new entity for all community-based adult mental health and addiction services in Grey Bruce. This work will amalgamate CMHA Grey Bruce, HopeGreyBruce and G&B House. The partners have signed a Memorandum of Understanding that commits them to working towards the establishing this single new community-based service in 2017/18.

In the short-term, service duplication will be eliminated, while in the long-term a new coordinated model will be implemented.

Update on South West LHIN initiatives

Strengthening primary care

Improving access to primary care is a focus of the South West LHIN's 2016-19 Integrated Health Service Plan. In 2016/17 work began in the South West LHIN to implement a multi-year collaborative primary care reform strategy to improve patient access and quality of care.

The core of this work will be connecting and integrating primary care providers with other care providers. There is also a need for dedicated work to respond to the needs of currently under serviced Indigenous communities.

In 2016, the South West LHIN in partnership with the West Elgin Community Health Centre jointly sponsored a study called Understanding Health Inequities and Access to Primary care in the South West LHIN to gain a better understanding of the needs of those facing multiple barriers to accessing health care. The study also worked to understand the changing demographics of both the general population and Primary Care Providers.

Based on the findings, our Primary Care Steering generated recommendations to support equitable access to primary care in the South West LHIN. The research focused on five vulnerable groups:

- Indigenous people;
- ethno-cultural groups and recent immigrants;
- rural residents;
- people with low socioeconomic status; and
- seniors.

The report identified five key barriers for these groups including poor timeliness of primary care, geographical, financial, health literacy, and poor relationships with health care providers. It also outlines five overarching recommendations that support equitable access to primary care including:

- Every person in the South West LHIN will have access to culturally safe primary care, regardless of their culture, economic status or where they live, that is provided by primary care providers who have the necessary knowledge and skills to communicate with patients such that the patients feel respected and receive information that they can understand and act on to improve their health.
- Every person in the South West LHIN will have timely access to primary care, including same day, next day, planned visits and after hours care.
- To support the provision of optimal (quality) primary care, all primary care providers must have access to timely, consistent, effective wrap-around services in office (or virtual) for patients aligned with need.
- Timely, quality primary care will be available to people in the South West LHIN by ensuring the right mix and distribution of primary health care providers throughout the region.
- Primary care providers will have access to shared information on patients including real time data and resources available to enable them manage the health of the population and work collaboratively with other health care providers in the provision of seamless care and services for their patients.

These recommendations will now inform a comprehensive, integrated and coordinated primary health care system in the South West LHIN.

Health Links

The Health Links approach to coordinated care planning continues to improve communication and collaboration among providers who share in the care of people with high care needs. Anyone with high care needs can benefit from this approach to care, with specific emphasis being placed on ensuring coordination of care for those with mental health and addictions challenges, those with palliative care needs, and those who are older and frail.

In the South West LHIN there are six geographies who are actively working with patients and their families to coordinate care: North Grey Bruce, South Grey Bruce, Huron Perth, London Middlesex, Oxford and Elgin, with Oxford and Elgin becoming active in January 2017.
In 2016/17, the Health Links approach has provided over 1,000 patients with the opportunity to experience coordinated care planning. Health care utilization and patients' confidence in meeting their goals are two of the indicators being monitored to determine success.

The Health Links Learning Collaborative is an action-oriented learning program to equip providers actively participating in the care coordination process to have the confidence and skills to work with patients and their families to achieve their goals. It is a staged program with 50-80 care providers attending each learning session. Learning sessions are case study based and have received positive feedback from participants.

Emergency wait times and alternate level of care pressures

Improving patient access and flow

Improving patient access and flow remains a key priority in the South West LHIN given challenges that remain with access to inpatient beds in hospitals. A key contributing factor to access challenges is alternate level of care (ALC) patients occupying hospitals beds, while their needs are better met in other care destinations.

Under the leadership of the Chief Nursing Executive Leadership Forum, the LHIN, CCAC, and all hospital providers in the South West LHIN (including Bluewater Health in the Erie St. Clair LHIN), continue to work together to improve key drivers of patient access and flow.

A holiday surge plan and protocol was again used during the 2016/17 Holiday season where proactive surge planning, a robust communications plan, and triggered triage huddle calls were used to ensure access and flow was maintained when predictable peaks in volume were seen. The process was successful as a result of collaboration between system partners and lower influenza activity in the region over the holiday period. It is intended that the holiday plan and protocol can be leveraged throughout the year to support periods of peak volume for services.

After considering current alignment with access and flow best practices, the Leadership Forum identified three priority areas for action:

1. Home First refresh
   An assessment highlighted the significant improvements achieved in the original Home First project (2013/14), and noted opportunities for improvement existed in the sustainability mechanisms used. Refreshing the principles of a Home First approach in all South West LHIN hospitals will focus on sustainability planning. A collaborative learning approach is being utilized.

2. Extraordinary Needs Patients

A considerable number of ALC days in hospital can be attributed to patients with extraordinary needs requiring non-traditional care destinations, the Leadership Forum has committed to better understanding this sub-population. Current initiatives and projects are underway to improve timeliness of, and care destinations for these patients.

3. A Regional Access and Flow Memorandum of Understanding (MOU) and Policy
   The South West LHIN OneNumber Protocol was updated in 2017 to reflect a stronger commitment of hospital partners to accept and complete repatriation and transfer requests for appropriate care closer to home for patients. Developing and implementing a broader regional access and flow MOU and policy will support shared accountability for access and flow between all hospital partners.

Home and community investments and strategies impacting seniors and adults with complex needs (both noted below) have supported the South West LHIN in consistently ranking within the top three LHINs with the lowest ALC rate.

Partnering to improve Emergency Department wait times

The South West LHIN continues to rank second best of 14 LHINs in Emergency Department (ED) wait times because of ongoing improvement and collaboration at high volume EDs in the South West LHIN. Through the Pay for Results (PFR) initiative, EDs continue to participate in a learning collaborative to improve wait times with targeted action plans for improvement. Participation includes leaders from the ED and Inpatient Units, and the CCAC to ensure a collaborative systems approach.

The approach also includes participation in the provincial ED Pay-for-Results program for eligible sites.

		South West LHIN								
Measure	Standard*	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17(YTD)
Time to PIA	< 4 hours	2.7	2.9	2.8	2.9	2.9	2.8	2.8	2.8	2.7
EDLOS Non-Admitted Low	≤ 4 hours	3.6	3.8	3.9	3.9	3.8	3.7	3.6	3.6	3.6
EDLOS Non-Admitted High	≤ 8 hours	5.9	6.0	6.4	6.5	6.5	6.4	6.2	6.2	6.1
EDLOS Admitted	≤ 8 hours	22.7	22.8	26.5	26.2	24.3	24.4	25.2	21	18.6
Consult Response Time	≤ 2 hours	N/A	N/A	N/A	2.9	2.7	2.7	2.8	2.6	2.4
Time to Decision to Admit	< 8 hours	9.5	10.1	10.3	10.6	10.6	10.0	9.9	9.0	9.0
Time to Inpatient Bed	≤ 2 hours	18.6	17.8	18.4	18.0	16.4	16.8	17.7	14	11.2
Number of New ALC Designations	N/A	N/A	N/A	N/A	2398	2642	2538	2460	3278	2702
ALC Rate	≤12.7%	N/A	N/A	N/A	14.0%	11.4%	11.0%	9.6%	11.1%	12.7%

Home and community services investments that better support seniors and other Ontarians

In 2016/17, the South West LHIN focused on advancing several key projects aimed at improving care for seniors and adults with complex needs by focusing on optimizing health, being responsive to their changing needs, and supporting safe and independent living in a fiscally responsible way.

The South West LHIN invested almost $10.6 million in ongoing support for the community sector, including funding to:

- Improve coordination and transitions of care for people accessing community support services, resulting in an integrated care model for coordinated care planning and

common intake across all community support service partner agencies.

- Expand the enhanced residential living model for young adults with complex needs and medical frailty to Owen Sound. This model enables people to live in the community with 24/7 specialized support, resulting in a better quality of life for the individual, caregiver respite, and health system efficiencies.
- Enable the expansion of front-line nursing and personal support services provision for high needs, complex clients and their caregivers in accordance with the Levels of Care Framework. This framework ensures greater consistency in the provision of home care services across the province and expands caregiver respite supports in accordance with the commitments of Ontario's *Patients First: A Roadmap to Strengthen Home and Community Care*.

In addition, almost $994,000 was invested in one-time funding to enable partners to purchase the supplies, equipment, vehicles and services required to start-up or expand programs.

Anchored in the province's *Patients First: A Roadmap to Strengthen Home and Community Care*, the LHIN began actively engaging with partners to design the infrastructure needed to implement the policies to expand personal support services and the CCAC/community support services integration. Implementing these policies will lead to a 'one-sector' experience for people. The integration will enable community support services to provide personal support services to older adults who are relatively independent, leaving the CCAC to focus on people with complex and post-acute needs.

In addition to the community sector focus, the South West LHIN advanced work in the long-term care sector. Three new attending nurse practitioners were funded to provide ongoing support to three long-term care homes in Huron, Perth and Oxford counties as part of the Ministry of Health and Long-Term Care's Nurse Practitioners in Long-Term Care Homes Initiative. The initiative aligns with the *Patients First: Action Plan for Health Care* by providing residents with care that is coordinated and integrated. These nurse practitioners are now in their roles and evaluation of the initiative will take place in 2017/18.

The South West LHIN is also supporting the Ministry's Long-Term Care Enhanced Renewal Strategy where 47 of the 78 long-term care homes in the LHIN are to redevelop a total of approximately 4,000 beds by 2025. The LHIN is working with long-term care home operators and the Ministry to ensure equitable access to high quality long-term care home beds throughout the LHIN geography, and leverage opportunities to create specialized units for people with responsive behaviours and other complex needs.

Hospice palliative care

South West LHIN partners continue to work towards a new vision for hospice palliative care. In alignment with Ontario's *Advancing High Quality High Value Palliative Care in Ontario: A Declaration of Partnership and Commitment to Action*, the South West LHIN Hospice Palliative Care Network's strategies place patients and families at the centre by working across all sectors and collaborating at regional, multi-community and local levels.

Five Hospice Palliative Care Collaboratives in Oxford, Elgin, Huron Perth, London Middlesex and Grey Bruce continue to implement an integrated model of hospice palliative care throughout the LHIN. Leadership for system change and in support of the collaboratives is provided by the South

West LHIN Hospice Palliative Care Leadership Committee.

In June 2016, the Province of Ontario announced the addition of 200 new residential hospice beds across Ontario by the end of 2018/19. To maximize their utility, residential hospice beds are being planned by the South West LHIN to be a part of an integrated system of care that includes a continuum of services to support individuals and families throughout their palliative journey, regardless of place of death.

In August 2016, the Ministry of Health and Long-Term Care confirmed the South West LHIN will receive additional annualized base funding for 2016/17 to support the expansion of residential hospice services offered by the Residential Hospice of Grey Bruce by increasing the number of funded beds from six to eight. These new beds will be sited at the new Chapman House location due to open in early 2017/18.

The LHIN has also received confirmation of Ministry support to establish 14 additional new hospice beds by 2018/19 to meet the LHIN's recommended bed allocation for the Grey Bruce (4) and Huron Perth (10) sub-regions.

In February, the South West LHIN Board of Directors made the decision to support a two-site residential hospice in Huron Perth with six beds in Stratford and four beds in Central Huron. The unified solution for Residential Hospice in Huron Perth that was supported by the board was based, in part, on the business plan prepared by Lough Barnes on behalf of the Huron Perth Hospice Palliative Care Collaborative.

Residential hospice is a specialized resource and as such, residential hospice beds will not be located in every community within the LHIN. As a multi-community service, implementation plans will ensure that as many people as possible in the South West LHIN will have access to residential hospice services within a reasonable travel distance from their homes.

Mental health and addiction services

Specialized Units

The South West LHIN's work associated with Access to Care and Behavioural Supports Ontario has influenced the direction to create specialized units in long-term care homes. These two initiatives have identified a population of individuals that consistently occupy acute and post-acute hospital beds and are unable to have their needs met by current resources. These individuals are often experiencing behavioural challenges resulting from advanced dementia, acquired brain injury, neurological disease or have mental health diagnoses and/or substance abuse issues.

To date, two requests for designation of specialized units in London Middlesex have been submitted to the Ministry for approval:

1. Kensington Village in partnership with Dale Brain Injury Services has proposed the creation of a 14-bed specialized unit that will enable the provision of a higher level of support required by some people living with an acquired brain injury. This level of support is currently not available but is necessary to meet the needs of this growing population within the South West LHIN.

2. McGarrell Place has proposed the creation of a 29 bed specialized unit that will enable the provision of a higher level of support required by some people living with responsive behaviours in a long-term care home. The specialized unit will aim to:

- Assess and stabilize unmanageable behaviours and support the transition of residents to return to their homes;
- Support the delivery of intensive behavioural support services in a long-term care setting as compared to a hospital-based assessment and treatment unit; and
- Allow for residents to receive the specialized services within the local community rather than being transferred to an outside community.

Mental health and addictions capacity planning

This project was initiated and endorsed by the South West LHIN, hospitals and CCAC to respond to significant access and flow pressures in Schedule 1 hospitals. To date, a clinical protocol aimed to improve patient access and flow for inpatient mental health and addiction beds has been developed and is ready to be implemented in each of the six Schedule 1 hospitals within the South West LHIN. A Psychiatry/Physician Lead will be working with the Chiefs of Psychiatry at each of the Schedule 1 hospitals to champion the implementation of the protocol and to identify gaps and opportunities in implementation.

A Mental Health and Addictions Capacity Planning Steering Committee will develop recommendations to inform a Mental Health and Addictions Capacity Plan for Schedule 1 and tertiary mental health hospitals within the South West LHIN. The committee will make recommendations for optimizing the effectiveness, efficiency, transparency and access to mental health beds. The Committee will also recommend how to align resources based on data and current resources.

One important tool used by the Committee is the Provincial Inpatient Mental Health and Addictions Bed Registry for Ontario hospitals which was launched in December 2015. The Bed Registry Project is comprised of two Mental Health and Addiction Resource Boards (one for adults and one for adolescents) and a Provincial Mental Health and Addiction Dashboard, all housed within CritiCall Ontario's existing Provincial Hospital Resource System.

The bed board provides province-wide up-to-date information about the number of available inpatient mental health and addictions beds in Ontario hospitals, and inpatient bed capacity information which is based on the number of individuals waiting for inpatient beds. The bed registry will be updated four times per day, seven days per week. This bed board will allow real time data on bed availability as well as the number of patients waiting for a bed in the emergency department at each of the Schedule 1 hospitals.

eHealth

In 2016/17 the South West LHIN continued to advance several key technology projects. While respecting the capacity and resources available, important steps were taken towards achieving excellence in health care by harnessing the power of information technology.

The South West LHIN and stakeholders, identified several eHealth initiatives or areas of focus that have the most direct impact in helping us meet our organizational priorities and are listed below.

eConsultation

The eConsultation project allows requesting clinicians (primary care providers and nurse practitioners) to communicate and collaborate electronically with specialists. This communication takes place over a secure web based platform provided by the Ontario Telemedicine Network (OTN). Currently more than 7,900 primary care

providers and 300 specialists from 120 fields across the province are registered to use this tool. A total of 277 clinicians and 28 specialists in the South West LHIN are active in the South West LHIN. OntarioMD and OTN field teams continue to engage providers and promote adopting this tool in the South West LHIN.

Health Links – Care Coordination Tool
The Care Coordination Tool documents the coordinated care plan that results from care conferences across all providers and the extended circle of support involved in managing the care of patients. The tool serves to facilitate collaboration by sharing timely information between those involved in the patient's care. The Huron Perth Health Link partners successfully completed piloting the Ministry's electronic version of the tool. Evaluation is currently underway to assess this tool and other interim electronic tools currently deployed in various Health Links areas across the province to arrive at a single provincial solution and strategy.

Regional integration (Clinical Connect)
Connecting South West Ontario (cSWO) is a Regional eHealth Program funded by eHealth Ontario. The program involves health service providers in the four Local Health Integration Networks of Erie St. Clair, South West, Waterloo Wellington and Hamilton Niagara Haldimand Brant.

cSWO's goal is to implement a regional ehealth program that will make an individual's health information from across the continuum of care available in a timely and secure fashion. This includes an integrated Electronic Health Record and a Regional Clinical Viewer, ClinicalConnect™. The regional ehealth program incorporates a number of related services, such as data support, adoption and change management, project management, privacy management and policy development.

ClinicalConnect is a secure online portal that provides authorized health care professionals with real-time access to their patients' electronic medical information (electronic health records) from local hospitals and CCACs. Information from provincial data repositories is also available, including Ontario laboratories information system and Southwestern Ontario Diagnostic Imaging Network Provincial Data Repositories. Care providers within a patient's circle of care can readily and securely access information about their patients, including reviewing their medications and test results. This provides a complete view of the patient's clinical journey through the health system.

ClinicalConnect has been deployed to more than 16,000 health professionals in the South West LHIN as of January, 2017. Among the four partnering LHINs there were 87,704 distinct patient records were viewed using ClinicalConnect in the month of January 2017. On average, this means 2,829 distinct patient records were viewed each day that month.

Hospital report systems
Hospital Report Manager is a provincial application that enables primary care providers and specialists using OntarioMD certified Electronic Medical Record systems anywhere in Ontario to receive patient reports electronically from participating hospitals or independent health facilities.

The cSWO Program and its partners are working collaboratively with OntarioMD to deploy and integrate Hospital Report Manager, including active engagement with the sending facilities (hospitals) and receiving organizations (clinicians). By January 2017, over 435 clinicians were using the application. In 2017/18 the application will continue to be deployed systematically to primary care physicians across South West Ontario, enhancing

their access to Electronic Medical Record download services.

Resource matching and referral
This initiative is a critical component of a positive patient experience in transitions of care. There is a plan to provincially standardize referral data from acute care to long-term care, the CCAC, complex continuing care and rehabilitation. Progress to date on the Resource Matching and Referral initiative is the result of significant engagement and collaboration with health service provider stakeholders across the province.

In 2016/17, collaboration between hospitals and the CCAC has resulted in progress in creating electronic forms to capture and record the referral information resulting in more efficient processes for clinicians.

Surgical wait list management
A surgical waitlist management system is an electronic, web-based solution that includes:

- Automated reporting to the provincial Wait Time Information System;
- Real-time wait time management in surgeons' offices;
- Real-time business intelligence for surgical waitlist management at all levels of the organization;
- Improved performance management and accountability;
- eScheduling from the physician office; and
- Paperless eBookings.

In 2015/16, the St. Thomas Elgin General Hospital led the first implementation and successful procurement of an electronic system. The evaluation has shown improvements in wait times (wait 2), operating room utilization, same day cancellation rates, and reduced staff time on clerical, booking and data entry. Implementation began in Huron Perth Healthcare Alliance and the Alexandra Marine and General Hospital in 2016/17. Expansion to other LHIN hospitals will continue in 2017/18.

Telehomecare
Telehomecare is an OTN project that allows remote monitoring of patients with Chronic Obstructive Pulmonary Disease and Congestive Heart Failure at home. A remote monitoring nurse engages to support patients for remote monitoring, coaching and self-management. The program is part of an integrated care process that involves the primary care provider and associated agencies providing care to the patient. In 2016/17, over 350 patients within the South West LHIN have been enrolled in this program.

Specialists services directory
The directory is an online catalogue designed to assist primary care physicians identify appropriate specialist services to make referrals. The electronic directory lists detailed information on sub-specialty services and procedures provided by the specialist including information on how to access these services, referral requirements, and referral forms. The electronic catalogue is hosted and maintained by the SouthWesthealthline.ca. This tool will help minimize rejected referrals and allow for easier and timely access to these services. A similar initiative is underway to capture primary care services available in the South West LHIN to facilitate greater access and continuity of care to citizens while avoiding unnecessary emergency room and walk-in visits.

Health System Funding Reform
Health System Funding Reform's initiative has two main components – the Health Based Allocation Model (HBAM) and Quality Based Procedures (QBPs), which look at quality, utilization and cost across

large South West LHIN hospitals and the CCAC.

Impacts in the South West LHIN
HBAM calculates a hospital's and CCAC's share of overall available funding by comparing an expected (standardized) total cost for the hospital to the sum of the expected cost of all Ontario hospitals. A single hospital's percentage share of the total provincial expected cost then determines the share of the available funding. Hospitals in the high growth areas of the province are receiving an increased share of the available funding as additional patient activity increases the total expected cost. The South West LHIN is growing, but not at the same pace as the Greater Toronto Area, and this results in flat or diminishing HBAM revenue for most of our hospitals. In 2016/17 additional HBAM investments were added to the provincial total which increased the funding to be shared between Health System Funding Reform hospitals.

Most South West LHIN hospitals have managed to work within available funding by keeping costs within Health System Funding Reform benchmarks (HBAM expected unit costs and QBP prices). For acute and day surgery, (the largest cost component of the HBAM model), South West LHIN hospitals have stayed close to or improved on HBAM expected unit cost levels. Based on the most recent HBAM results, four of the seven Health System Funding Reform hospitals reported lower actual unit costs than the HBAM cost benchmark. Staying close to HBAM unit cost benchmarks does not equate to compromised service standards. Lowering ED costs can mean increased efficiency and lower wait times, maintaining or lowering acute care costs can be achieved by standardizing best practices and reducing average length of stay.

Partnership with health service providers

The South West LHIN has been working with its Health System Funding Reform Local Partnership Committee to shift focus from change management related to the financial aspects of funding reform toward quality outcomes, and broaden membership participation to include greater representation from clinical, and improvement leadership.
The following are three key areas of focus:

1. Implement and adopt QBP evidence-based practices and improvement in outcomes
2. Implement and spread Integrated Funding Model/ Bundled Care
3. Volume Planning and Management

Implement and adopt Quality Based Procedures evidence-based practices and improving outcomes
LHINs across Ontario have been working together to implement a cross-LHIN QBP Assessment Survey to better understand how QBPs are implemented in order to further support implementation and change management related to Health System Funding Reform. Involved partners found initial results to be informative and helped gauge adoption and sustainability of best practices. The results also proved to be a catalyst for hospitals to share learnings across partners. The second pan-LHIN Assessment Survey was completed in October 2016 with the following key objectives:

1. Profile the current state and provide an update on emerging opportunities and next steps related to QBP implementation within and across LHINs
2. Identify potential areas where collective action could increase efficiency and improve performance (within and across LHINs).

To support spread and scale of key outcome improvements, key partners from

LHINs, the Ministry, the Ontario Hospital Association, and Health Quality Ontario are working together in order to identify, promote, and share "leading practices of high performing organizations" for specific QBPs. Peer learning knowledge transfer sessions are being planned throughout 2017/18 to support spread and scale of leaders. Locally, South West LHIN results will be shared with Local Partnership Committee to support overall improvement.

Implement Integrated Funding Models/Bundled Care

Over 100 patients with moderate intensity needs related to Chronic Obstructive Pulmonary Disease are enrolled now through the Connecting Care to Home project (one of six pilot projects across the province.) Enrolled patients discharged home from London Health Sciences Centre experienced an integrated and coordinated system of care based on evidence-based practice as they transitioned from hospital to the community for up to 60 days. Focused on integrating current hospital and funding home and community care, patients are supported by an innovative eShift model that allows for remote monitoring of patients and other technology, 24/7 access to the clinical team, navigator, clinical care coordinator, dedicated home care provider, ambulatory clinics, and electronic medical record as well as connections with specialists and primary care. Outcomes for this work show reduced hospital lengths of stay, fewer ED visits and readmissions for patients supported on the integrated pathway. The LHIN and system partners are currently working on a spread strategy for bundled funding initiatives in the South West.

Volume Planning and Management

A new protocol was developed and implemented in the South West LHIN in consultation with the Local Partnership Committee to optimize volume reallocation opportunities. A QBP and wait time volume management process was also developed and integrated into the Quarter 2 and 3 Quarterly Service Accountability Agreement Review Process. This process has enabled ongoing management of QBP volumes with health service providers, and an opportunity to formally escalate follow-up through the Service Accountability Agreement process, when required, to maximize volume allocations and distributions.

A new provincial population-based QBP volume planning tool is under development, which focuses on developing a volume planning model (based on prevalence of key risk factors) for primary unilateral hip and knee replacement surgery volumes.

Wait times for surgical and diagnostic imaging procedures

Orthopaedic (Hip and Knee) initiatives to improve wait times

In 2016/17 the South West LHIN focused on strategies and initiatives to improve experiences for patients and the quality of reported wait times. These strategies include:

1. **Data Clean-Up**
   A list of patients who are on more than one wait list for hip and knee replacement were shared with wait time coordinators at each hospital for action. Also, hospitals have implemented a process to clean-up their wait lists to remove duplicates and ensure cases are appropriately prioritized. Poor data quality can negatively impact reported wait times.

2. **2016/17 one-time investment**
   In February 2017, $575,800 in one-time funding was provided to support patients with the longest wait times (more than 16 months) for hip or knee replacement surgery in the South West LHIN. Funding was provided to London

Health Sciences Centre, Strathroy Middlesex General Hospital, Stratford General Hospital, and Woodstock General Hospital for an additional 103 hip and knee replacement surgeries to be completed by March 31, 2017. It was expected that these procedures were completed over and above year end projections and did not interrupt any previously scheduled patient surgeries.

An additional one per cent base funding increase was provided to London Health Sciences Centre to support the continued provision of services to meet community health care needs and to support achievement of its Hospital Service Accountability Agreement (H-SAA) performance obligations. A total of $1,000,000 of the new base funding is to be directed to improve hip and knee replacement service wait time performance in this hospital.

3. **Orthopaedic Steering Committee**
In October 2016, a current state review of regional performance in access, quality, and patient experience was completed. Committee members agreed that patients are waiting too long and that there is a considerable variation in wait times among surgeons and health service providers in the region. As a result, the Committee prioritized the following opportunities for immediate action, and have established working groups to address:

- **Priority 1** – Providing primary care with regular updates on Wait 1 (the time that a patient waits for a first consultation with a surgeon) and Wait 2 (the time that a patient waits from first consultation to surgery) data by site and surgeon. Expected completion by summer 2017.
- **Priority 2** – Centralize the intake of all hip and knee referrals from primary care to an orthopaedic surgeon within the South West LHIN. Expected completion by spring 2018.
- **Priority 3** – Create a regional Orthopaedic performance dashboard report to guide Steering Committee actions. Expected completion is summer 2017.

Vision care
The LHIN provided funding through the Priorities for Investment Fund to support vision screening for people with diabetes and visual acuity testing pre- and post-cataract surgery.

Diabetes vision screening investments were made to increase the rate people with diabetes access eye exams in order to control diabetes-related eye disease. An awareness campaign was developed and launched since 31 per cent of patients surveyed at the outset of the project indicated they did not know diabetes is a leading cause of blindness. A total of 91 per cent of respondents said they would book an appointment for vision screening after reading the awareness campaign brochure.

Visual acuity testing pre- and post-cataract surgery investments were made to develop and test a process for consistently collecting pre- and post-cataract surgery visual acuity scores as a measurement of clinical outcome.

Diagnostics initiatives to improve wait times
The South West LHIN has continued investments to improve the diagnostics wait times. In partnership with the regional and local stakeholders, $328,000 was invested to continue the creation of a new

regional model called the Medical Imaging – Regional Service Model.

The Regional Medical Imaging Committee has identified three key areas of focus to improve imaging services within the region:

- Standardization of Quality: Leveraging the opportunity to standardize protocols, LHIN-wide peer review practices and established quality metrics for imaging services.
- Appropriateness: Using improved access to prior exams, a common and improved ordering/referral/scheduling system that supports appropriateness, online education at the point of ordering, and information filtering for radiologist prioritization, looking at all modalities.
- Access: A wait list management strategy includes supporting designating which services are available at what sites based on sub-specialty skills, equipment features and appropriate equipment utilization, and mechanisms to real-time direct demand to where capacity exists to improve the LHIN-wide wait list across all modalities.

Recognizing MRI wait times exceed provincial targets, the South West LHIN invested $185,900 into additional MRI operating hours targeting the longest waiting priority four patients. This patient-centred approach ensured investments were targeted at the patient and priority level with the longest wait times. A total of 715 additional MRI operating hours were funded between St. Joseph's Health Care London, London Health Sciences Centre, Woodstock General Hospital and Stratford General Hospital based on sites capacity to complete additional hours.

Diabetes program update

The South West LHIN tested and established coordinated access for diabetes education as part of a pilot project. The Diabetes Coordinated Access project's aim is to work with the diabetes education programs to develop standard processes related to intake, referral and placement of patients. This work is currently focused on health service providers in the London area. The London focus will continue to spread including to St. Joseph's Health Care Diabetes Education Centre to ensure patients are receiving appropriate services in the right place and in accordance with established wait times based on acuity level. Efforts will now be to spread these standards across the full London Middlesex sub-region in the coming year.

The nine Diabetes Education Programs have taken significant steps to monitoring and evaluating their clinical outcomes by engaging in a threefold quality improvement initiative. All programs have collected and reported data on the clinical indicator HbA1c (a patient self-efficacy score) and participated in an Experienced Based Design survey. The outcomes of these quality improvement investigations will be reported in early 2017/18.

The Diabetes Foot Care project focuses on an integrated, interdisciplinary team delivery model. The project leverages existing services and organizations to address diabetes foot care needs in the London area using risk-based stratification. The project has been scoped within the larger Diabetes Coordinated Access project to ensure linkages between intake and referral processes, and formal testing of the harmonized risk stratification model are in place.

Local Health System Performance

The Ministry LHIN Accountability Agreement (MLAA) outlines obligations and responsibilities of both the South West LHIN and the Ministry of Health and Long-Term Care (MOHLTC) and specifies indicators targeted for improvement. The 2015-2018 MLAA reflects alignment with the new government priorities and initiatives including the *Patients First Action Plan for Health Care*, and transformation activities including: Home and Community Care, Health System Funding Reform (HSFR), Health Links, Comprehensive Mental Health and Addictions Strategy, and Palliative Care.

Effective 2015/16, the Ministry shifted to using a single target for each indicator for all LHINs versus LHIN-specific targets. LHINs must report on and demonstrate progress towards achieving the provincial targets for *performance* indicators and report on and monitor the results of the *monitoring* indicators.

The subsequent table on page 39 reports on the performance of the South West LHIN on key MLAA measures.

Performance Indicators
Considering both the most recent quarter of data and the 2016/17 annual performance result, the South West LHIN has either met the provincial target or made progress against the 2014/15[10] result for the following MLAA performance indicators:

- 90th percentile emergency department (ED) length of stay for complex patients.
- 90th percentile emergency department (ED) length of stay for minor/uncomplicated patients
- Percent of priority 2, 3 and 4 cases completed within access target for MRI scans
- Percent of priority 2, 3 and 4 cases completed within access target for CT scans
- ALC rate

LHIN/provider actions and initiatives that contributed to the improved outcomes include:

- A Regional Medical Imaging Integrated Care Project to develop strategies to standardize quality, appropriateness, and access through integrating medical imaging services has been designed to support the South West to realize improvements over baseline despite increasing demands for MRI.
- The ED Pay-for-Results (P4R) and Knowledge Transfer (KT) Learning Collaborative have targeted an improvement and investment approach at high volume ED sites to drive improvement in ED metrics. The focus of this work is on improving patient flow (including ED and ALC measures).
- As part of the broader patient flow improvement approach, a Home First Refresh (focused on ALC avoidance and management strategies) has been implemented at London Health Sciences Centre, demonstrating an overall reduction in the number of open ALC cases, and open ALC cases waiting for long-

[10]the baseline year prior to the effective date of the MLAA

term care. A spread strategy across the South West LHIN is underway to enhance positive impacts. Additionally, investments in CCAC nursing to support Home First patients, investments made to increase access to Assisted Living spaces based on demographic data and demand, support for Behavioural Supports Ontario to provide coordination and expertise in supporting and transitioning difficult-to-serve ALC clients, and support for coordinated access to Complex Continuing Care and Rehabilitation beds have all contributed to the South West LHIN consistently performing among the top four best LHINs on ALC rate.

The South West LHIN has not achieved the provincial target in the most recent quarter for Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions but did demonstrate a slight improvement over 2014/15 with its 2016/17 annual performance. Enhancing community capacity through investments in Transitional Case Management and Crisis Services (including five stabilization beds and 24/7 walk-in access to the Crisis Centre to provide short-term support for individuals with a mental health and/or addictions crisis in London) and collaboration among community mental health partners to develop a Coordinated Access model of care to improve accessibility and work to identify potential service gaps and improvement opportunities for patients who frequently visit the ED have contributed to sustained or slightly improved performance despite increasing pressures and volumes of patients visiting EDs for mental health conditions.

A Peer Support strategy as well as the development of clinical protocols to guide the utilization and transition between services are expected to have future positive impacts on Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions.

Alternatively, despite meeting the provincial target for 90th Percentile Wait Time for CCAC In-Home Services: Application from Community Setting to first CCAC Service (excluding case management) for the most recent quarter, the 2016/17 annual result for the South West LHIN did not demonstrate improvement from 2014/15. The decline in performance was brief (i.e. one quarter) and aligned with both continued increases in demand for services for complex and chronic clients as well as an exceptionally long wait recorded for a patient that was later attributed to a data quality issue.

Considering both the most recent quarter of data and the 2016/17 annual performance result, the LHIN has neither achieved the provincial target, nor improved, when compared to 2014/15 for the following performance indicators:

- Percent of priority 2, 3 and 4 cases completed within access target for hip replacement
- Percent of priority 2, 3 and 4 cases completed within access target for knee replacement
- Readmission within 30 days for selected HIG conditions.
- Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services
- Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services.

- Percentage Alternate Level of Care (ALC) Days
- Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions

The South West LHIN has consistently demonstrated better-than-province performance in the latter three measures, however.

Some of the challenges that may have contributed to these outcomes include:

- Despite provincial and LHIN targeted investment/additional volumes allocated to South West LHIN hospitals to support patients waiting the longest (greater than 16 months), the demand for hip and knee surgeries continues to be a challenge for most hospitals.
- A higher-than-expected overall readmission rate in the South West LHIN is observed largely as a result of readmissions for gastrointestinal infections. Readmission rates are also higher-than-expected for other complex and chronic conditions such as pneumonia, acute myocardial infarction, stroke, and congestive heart failure and most of the interventions that South West LHIN providers have implemented for patients with these conditions are still early in reaching a critical mass.
- Increases in complex referrals--especially over the holiday season--have resulted in the CCAC coming up short of the ambitious 95 per cent targets for home care access within 5 days. Further, the South West LHIN also has e-shift supports which is not provided by most LHINs. The e-shift services are challenged by staffing shortages and increases in demand for end of life palliative patients, especially over the Christmas period. In addition, the South West LHIN is the only LHIN that provides Geriatric Resource Nursing (GRN) Services. The model adopted for this program is not designed for a visit within 5 days. Without GRN Services being considered, the performance on this indicator would be improved.
- Though ALC days in acute beds for the South West LHIN is generally around the second lowest among Ontario LHINs, performance has declined since baseline as a result of increasing complexity (i.e. social, behavioural, financial) of patients as well as the challenge associated with patients waiting in hospital as ALC for a first-choice, long-waitlist LTC home.
- There continues to be observed increases in co-occurring mental health and/or substance abuse conditions in patients who frequently visit the ED, exacerbated by both the opioid and crystal methamphetamine crises.

Actions the LHIN has undertaken or plans to undertake to improve performance include:

- Surgical Wait List Management System planning and implementation is underway as is regional and organizational data clean up action championed by the South West LHIN Decision Support Network to remove duplicate wait list entries and ensure that we understand true demand for procedures. Based on

sustained demand pressures in the South West LHIN, the LHIN has targeted additional investment to support expedited completion of hip and knee replacement surgeries for patients who have been waiting the longest for their surgeries. Further, the Orthopedic Steering Committee has been re-constituted with a short-term focus on access for hip and knee patients including developing better mechanisms to share wait time information by organization and surgeon with primary care providers in the South West LHIN- leveraging lessons learned through implementation in Waterloo Wellington LHIN.

- Though early in implementation, there are a number of interventions that have been implemented in the South West LHIN to improve readmission rates including: Health Links, Telehomecare, an Integrated Funding Model pilot known as "Connecting Care to Home" (CC2H) for chronic obstructive pulmonary disease (COPD) patients, and improving the timeliness of sending discharge summaries from hospitals to primary care physicians. Importantly, improvements in readmissions for COPD patients have been demonstrated over a six month timeframe as a result of CC2H.
- Focused performance monitoring discussions with CCAC include 5-day wait measures and have been routinely completed. An escalating series of follow-up requirements is initiated with the CCAC if it falls outside of its allowed corridor requiring explanation, improvement planning, and further reporting. Enhanced CCAC base funding to expand service provision to clients with complex, high-needs as well as for caregiver respite should ease pressures in other areas to allow for a focus on ensuring wait time improvements.
- An Alternate Level of Care (ALC) Avoidance and Patient Flow initiative led by regional Chief Nursing Executives has resulted in task teams to realize further improvements in ALC and discharge planning including strategies for extraordinary needs patients (i.e. difficult-to-serve ALC patients). Additionally, planning to enhance Behavioural Support Unit (BSU) capacity is underway and will ease ALC pressures once developed.
- Strategies implemented to improve ED revisit rates for mental health conditions referenced above also aim to improve revisit rates for substance abuse conditions.

Monitoring Indicators

Considering both the most recent quarter of data and the 2016/17 annual performance result, the South West LHIN continues to surpass the provincial target for Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery and has demonstrated improvements over 2014/15 for Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery. Though there are no provincial targets, the South West LHIN demonstrated better results than the province for CCAC wait times from application to eligibility determination for long-term care home placements (from community setting) and CCAC wait times from application to eligibility determination

for long-term care home placements (from acute-care setting).

Considering both the most recent quarter of data and the 2016/17 annual performance result, the LHIN has neither achieved the provincial target, nor improved, when compared to 2014/15 for Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery. Though the majority of South West LHIN hospitals have not met the 90% access target, collectively the South West LHIN surpassed provincial performance in the most recent quarter.

The South West LHIN's investments in Vision Care initiatives have focused on clinical outcomes instead of squarely on improving wait times over the past two years, and this could explain the lack of improvement progress. The Vision Care Steering Committee remains in place and it is anticipated that the Committee will continue to work on the recommendations identified in the March 2015 Vision Care Clinical Services Planning report. Wait time improvement opportunities may be prioritized the Committee.

Though there are no provincial targets, the most recent quarter and the 2016/17 annual provincial Rate of emergency visits for conditions best managed elsewhere (per 1,000 population), Hospitalization rate for ambulatory care sensitive conditions (per 100,000 population), and percentage of acute care patients who had a follow-up with a physician within seven days of discharge are all better than the South West LHIN performance. 63 per cent of residents living in the South West LHIN's geography who responded to the Health Care Experience Survey over the past year reported difficulty accessing medical care in the evenings/weekends and on holidays without going to the ED (Ontario: 54 per cent). Avoidable ED visits are highest in the Grey Bruce sub-region. This sub-region has the highest proportion of the population without access to a consistent primary care provider (13.5 per cent). Primary Care Capacity Planning and targeted physician recruitment in working with Health Force Ontario aim to improve attachment and access to primary care providers.

Overall, these measures are inherently complex and multi-faceted and thus require cross-sector collaboration to improve. Spreading best hospital discharge practices including improving communication between primary health care providers and hospitals and supporting and facilitating the development of Health Links represent actions the LHIN has undertaken to improve performance. Further, as we transition into a focus on improvements within sub-regions and Patients First, a greater emphasis on collaboration, integration and shared accountability will enable health service providers across all sectors to better contribute to improvements in these system measures.

SOUTH WEST LHIN MLAA INDICATORS
2016/17 ANNUAL REPORT DATA

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
1. Performance Indicators										
1	Percentage of home care clients with complex needs who received their personal support visit within 5 days of the date that they were authorized for personal support services*	95.00%	85.39%	85.36%	82.10%	85.58%	90.87%	88.95%	85.16%	87.88%
2	Percentage of home care clients who received their nursing visit within 5 days of the date they were authorized for nursing services*	95.00%	93.71%	94.00%	93.83%	94.53%	92.59%	93.10%	91.77%	92.00%
3	90th Percentile Wait Time for CCAC In-Home Services - Application from Community Setting to first CCAC Service (excluding case management)*	21 days	29.00	29.00	29.00	31.00	21.00	21.00	21.00	22.00
4	90th percentile emergency department (ED) length of stay for complex patients	8 hours	10.13	9.97	11.03	10.38	8.37	7.73	7.98	7.73
5	90th percentile emergency department (ED) length of stay for minor/uncomplicated patients	4 hours	4.03	4.07	4.23	4.15	3.62	3.62	3.72	3.60
6	Percent of priority 2, 3 and 4 cases completed within access target for MRI scans	90.00%	41.75%	38.43%	40.76%	40.17%	34.41%	33.92%	53.05%	45.20%
7	Percent of priority 2, 3 and 4 cases completed within access target for CT scans	90.00%	77.77%	74.66%	78.31%	75.89%	76.82%	78.43%	86.63%	84.54%
8	Percent of priority 2, 3 and 4 cases completed within access target for hip replacement	90.00%	81.51%	79.97%	77.89%	78.47%	76.53%	68.39%	40.88%	50.35%
9	Percent of priority 2, 3 and 4 cases completed within access target for knee replacement	90.00%	79.76%	79.14%	74.50%	75.02%	76.83%	68.86%	45.58%	47.56%

No.	Indicator	Provincial target	Provincial				LHIN			
			2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)	2014/15 Fiscal Year Result	2015/16 Fiscal Year Result	Most Recent Quarter	2016/17 Result (year-to-date)
10	Percentage of Alternate Level of Care (ALC) Days*	9.46%	14.35%	14.50%	15.85%	15.16%	8.39%	9.24%	10.67%	10.45%
11	ALC rate	12.70%	13.70%	13.98%	15.27%	15.19%	9.65%	11.05%	10.25%	11.68%
12	Repeat Unscheduled Emergency Visits within 30 Days for Mental Health Conditions*	16.30%	19.62%	20.19%	20.39%	19.81%	17.64%	18.00%	18.61%	17.51%
13	Repeat Unscheduled Emergency Visits within 30 Days for Substance Abuse Conditions*	22.40%	31.34%	33.01%	31.15%	31.40%	21.08%	23.06%	23.16%	23.65%
14	Readmission within 30 days for selected HIG conditions**	15.50%	16.60%	16.65%	16.66%	16.51%	17.34%	17.19%	17.56%	17.37%
2. Monitoring Indicators										
15	Percent of priority 2, 3 and 4 cases completed within access target for cancer surgery	90.00%	87.02%	88.03%	86.82%	87.23%	81.49%	84.29%	86.13%	85.06%
16	Percent of priority 2, 3 and 4 cases completed within access target for cardiac by-pass surgery	90.00%	96.01%	95.00%	93.00%	93.00%	98.92%	98.00%	98.00%	98.00%
17	Percent of priority 2, 3 and 4 cases completed within access target for cataract surgery	90.00%	91.93%	88.09%	85.32%	85.01%	88.52%	91.27%	85.94%	83.57%
18 (a)	CCAC wait times from application to eligibility determination for long-term care home placements: from community setting**	NA	14.00	14.00	14.00	14.00	8.00	9.00	7.00	8.00
18 (b)	CCAC wait times from application to eligibility determination for long-term care home placements: from acute-care setting**	NA	8.00	7.00	8.00	8.00	4.00	4.00	3.00	3.00
19	Rate of emergency visits for conditions best managed elsewhere per 1,000 population*	NA	19.56	18.47	4.58	12.28	46.03	42.56	11.10	29.72
20	Hospitalization rate for ambulatory care sensitive conditions per 100,000 population*	NA	320.78	320.13	81.88	241.40	389.32	397.79	105.43	312.84
21	Percentage of acute care patients who had a follow-up with a physician within 7 days of discharge**	NA	46.09%	46.61%	47.46%	47.81%	40.80%	42.37%	42.62%	43.58%

*FY 2016/17 is based on the available data from the fiscal year (Q1-Q3, 2016/17)

**FY 2016/17 is based on the available data from the fiscal year (Q1-Q2, 2016/17)

Operational Performance

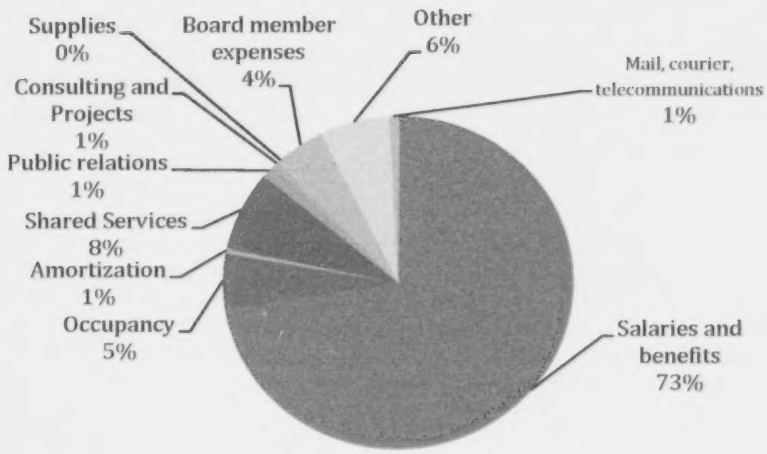
In 2016/17, the South West LHIN operating budget was made up of two components:

- $4.9 million for operations
- $2.1 million for special projects

Operations

The South West LHIN ended the year with an operating surplus of $440. Surpluses are returned to the Ministry. The chart below shows the 13 major categories of expenditures for the South West LHIN. Our largest expenditure was salaries and benefits with 33 full-time employees (FTEs) which included two contract staff.

Operational Expenditures 2016/17



Salaries and benefits	**$3,524,261**
Occupancy	**$261,899**
Amortization	**$21,618**
Shared services	**$325,506**
LHIN Collaborative	**$52,714**
Public relations	**$66,080**
Consulting and Project expenses	**$29,529**
Supplies	**$15,170**
Board chair per diem	**$61,089**

Board member per diem	**$72,767**
Board member expenses	**$76,323**
Mail, courier and telecommunications	**$42,595**
Other	**$313,227**
	$4,862,778

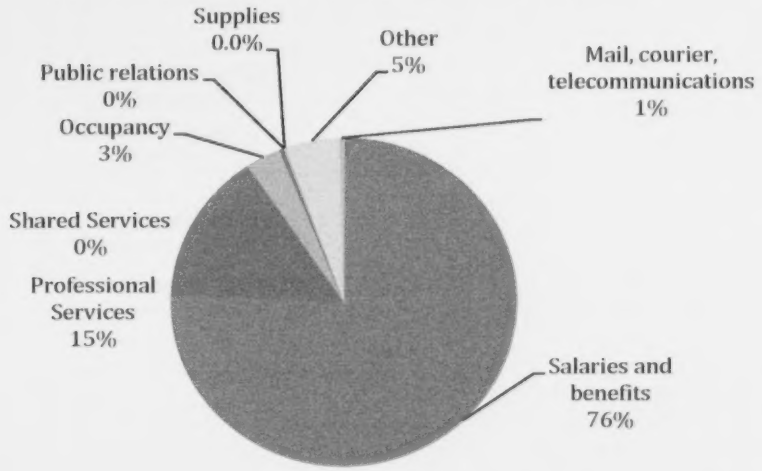
Special projects

The South West LHIN ended the year with surpluses of $90,390 relating to the funding for other special projects. Surpluses are returned to Ministry of Health and Long-Term Care. The chart below shows the 8 major categories of expenditures. Again, the largest expenditure was salaries and benefits with 14 FTEs including one contract position.

The base and one-time funding received and expenditures by the South West LHIN to plan and develop special projects during 2016/17:

Salaries and benefits	**$1,772,305**
Professional services	**$348,778**
Shared services	**$10,067**
Occupancy	**$77,033**
Public relations and community engagement	**-**
Supplies	**$3,797**
Mail, courier and telecommunications	**$10,534**
Other	**$119,238**
	$2,341,752

Special Projects Expenditures 2016/17



Enabling Technology Integration

Effective January 31, 2014, the LHIN entered into an agreement with three LHINs, Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "cluster"), to enable effective and efficient delivery of e-health programs and initiatives within the geographic area of the cluster. The total cluster funding for the year ended March 31, 2017 was $2,040,000. Funding of $1,530,000 was allocated to other LHINs within the cluster who incurred eligible expenses of $1,530,000. The South West LHIN had expenses of $502,524 relating to project management for enabling technology integration.

Financial statements of

South West Local Health Integration Network

March 31, 2017

South West Local Health Integration Network

March 31, 2017

Table of contents

Independent Auditor's Report 1-2

Statement of financial position 3

Statement of operations 4

Statement of change in net debt 5

Statement of cash flows 6

Notes to the financial statements 7-15

Deloitte.

Deloitte LLP
400 Applewood Crescent
Suite 500
Vaughan ON L4K 0C3
Canada

Tel: 416-601-6150
Fax: 416-601-6151
www.deloitte.ca

Independent Auditor's Report

To the Members of the Board of Directors of the
South West Local Health Integration Network

We have audited the accompanying financial statements of South West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2017, and the statements of operations, change in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of South West Local Health Integration network as at March 31, 2017 and the results of its operations, changes in its net debt, and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte LLP

Chartered Professional Accountants
Licensed Public Accountants
May 16, 2017

South West Local Health Integration Network

Statement of financial position
as at March 31, 2017

	2017	2016
	$	$
Financial assets		
Cash	**648,278**	435,353
Due from Ministry of Health and Long-Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**7,656,700**	13,455,322
Harmonized sales tax receivable	**32,175**	36,227
Accounts Receivable - other	**7,606**	-
	8,344,759	13,926,902
Liabilities		
Accounts payable and accrued liabilities	**600,480**	424,798
Due to Health Service Providers ("HSPs") (Note 9)	**7,656,700**	13,455,322
Due to MOHLTC (Note 3b)	**96,317**	61,122
Due to the LHIN Shared Services Office (Note 4)	-	8,708
Deferred capital contributions (Note 5)	**44,290**	43,594
	8,397,787	13,993,544
Net debt	**(53,028)**	(66,642)
Commitments (Note 6)		
Non-financial assets		
Prepaid expenses	**8,738**	23,048
Tangible capital assets (Note 7)	**44,290**	43,594
	53,028	66,642
Accumulated surplus	-	-

Approved by the Board

Director

Director

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of operations
year ended March 31, 2017

	Budget (Note 8)	2017 Actual	2016 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSP transfer payments (Note 9)	**2,249,599,783**	**2,309,811,966**	2,258,840,834
Operations of LHIN	**4,887,225**	**4,841,600**	5,018,025
Project Initiatives			
Aboriginal Planning	**35,000**	**35,000**	35,000
French Language Services	**106,000**	**106,000**	106,000
Critical Care	**75,000**	**75,000**	75,000
Emergency Department ("ED") Lead	**75,000**	**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead	**100,000**	**100,000**	100,000
Primary Care Lead	**75,000**	**75,000**	75,000
Enabling Technologies ETI PMO	**2,040,000**	**2,040,000**	2,040,000
Diabetes Regional Coordinating Centre	**1,168,523**	**1,168,523**	1,168,523
Patients First Transition Planning and Implementation	-	**180,000**	-
Patients First Pan-LHIN Support for Planning and Implementation	-	**107,619**	-
Amortization of deferred capital contributions (Note 5)	**21,618**	**21,618**	32,826
	2,258,183,149	**2,318,637,326**	2,267,566,208
Enabling Technologies ETI PMO allocated to other LHIN's	**(1,530,000)**	**(1,530,000)**	(1,530,000)
Funding repayable to the MOHLTC (Note 3a)	-	**(90,830)**	(5,486)
	2,256,653,149	**2,317,016,496**	2,266,030,722
Expenses			
Transfer payments to HSPs (Note 9)	**2,249,599,783**	**2,309,811,966**	2,258,840,834
General and administrative (Note 11)	**4,908,843**	**4,862,778**	5,050,623
Project Initiatives (Note 10)			
Aboriginal Planning	**35,000**	**26,598**	34,930
French Language Services	**106,000**	**105,042**	105,774
Critical Care	**75,000**	**73,111**	72,886
ED Lead	**75,000**	**37,070**	74,972
ER/ALC Performance Lead	**100,000**	**100,000**	99,746
Primary Care Lead	**75,000**	**64,944**	73,127
Enabling Technologies	**510,000**	**502,524**	509,487
Patients First Transition Planning and Implementation	-	**167,828**	-
Patients First Pan-LHIN Support for Planning and Implementation	-	**107,619**	-
Diabetes Regional Coordinating Ctr	**1,168,523**	**1,157,016**	1,168,343
	2,256,653,149	**2,317,016,496**	2,266,030,722
Annual surplus and accumulated surplus, end of year	-	-	-

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of change in net debt
year ended March 31, 2017

	2017 Actual $	2016 Actual $
Annual surplus	-	-
Change in prepaid expenses, net	**14,310**	(5,890)
Acquisition of tangible capital assets	**(22,314)**	(7,695)
Amortization of tangible capital assets	**21,618**	32,826
Decrease in net debt	**13,614**	19,241
Net debt, beginning of year	**(66,642)**	(85,883)
Net debt, end of year	**(53,028)**	(66,642)

The accompanying notes to the financial statements are an integral part of these financial statements.

South West Local Health Integration Network

Statement of cash flows
year ended March 31, 2017

	2017	2016
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**21,618**	32,826
Amortization of deferred capital contributions (Note 5)	**(21,618)**	(32,826)
Changes in non-cash operating items		
Due from MOHLTC HSP transfer payments	**5,798,622**	345,265
Accounts receivable	**(7,606)**	55,905
Harmonized Sales Tax receivable	**4,052**	45,761
Accounts payable and accrued liabilities	**175,682**	(28,542)
Due to HSPs	**(5,798,622)**	(345,265)
Due to MOHLTC	**35,195**	5,486
Due to LHIN Shared Services Office	**(8,708)**	(50,171)
Prepaid expenses	**14,310**	(5,890)
	212,925	22,549
Capital transaction		
Acquisition of tangible capital assets	**(22,314)**	(7,695)
Financing transaction		
Deferred capital contributions received (Note 5)	**22,314**	7,695
Net increase in cash	**212,925**	22,549
Cash, beginning of year	**435,353**	412,804
Cash, end of year	**648,278**	435,353

The accompanying notes to the financial statements are an integral part of these financial statements.

1. Description of business

The South West Local Health Integration Network was incorporated by Letters Patent on July 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the South West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers approximately 22,000 square kilometers from Tobermory in the north to Long Point in the south. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with the Ministry-LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario - LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian public sector accounting standards. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible capital assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. Unspent amounts are recorded as payable to the MOHLTC at period end. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed.

Deferred capital contributions

Any amounts received that are used to fund expenses that are recorded as tangible capital assets, are recorded as deferred capital revenue and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of operations, is in accordance with the amortization policy applied to the related tangible capital asset recorded.

Tangible capital assets

Tangible capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of tangible capital assets. The cost of tangible capital assets contributed is recorded at the estimated fair value on date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a tangible capital asset are capitalized. Computer software is recognized as an expense when incurred.

Tangible capital assets are stated at cost less accumulated amortization. Tangible capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use, during the year, amortization is provided for a full year.

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of operations and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and, therefore, no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant items subject to such estimate and assumptions include valuation of accrued liabilities and useful lives of the tangible capital assets. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to eHealth Ontario.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Funding	Eligible expenses	2017 Funding excess	2016 Funding excess
	$	$	$	$
Transfer payments to HSPs	2,309,811,966	2,309,811,966	-	-
LHIN operations	4,841,600	4,841,160	440	228
Aboriginal Planning	35,000	26,598	8,402	70
French Language Services	106,000	105,042	958	226
Enabling Technologies	2,040,000	2,032,524	7,476	513
Critical Care Lead	75,000	73,111	1,889	2,114
ED Lead	75,000	37,070	37,930	28
Primary Care Lead	75,000	64,944	10,056	1,873
ER/ALC Lead	100,000	100,000	-	254
Patients First Pan-LHIN Support for Planning and Implementation	107,619	107,619	-	-
Patients First Transition Planning and Implementation	180,000	167,828	12,172	-
Diabetes Regional Coor. Centres	1,168,523	1,157,016	11,507	180
	2,318,615,708	2,318,524,878	90,830	5,486

b) The amount due to the MOHLTC at March 31 is made up as follows:

	2017	2016
	$	$
Due to MOHLTC, beginning of year	61,122	55,636
Funding repaid to MOHLTC	(55,636)	-
Funding repayable to the MOHLTC related to current year activities (Note 3a)	83,354	4,973
Funding repayable to the MOHLTC related to current year ETI PMO Cluster activities	7,476	513
Due to MOHLTC, end of year	96,316	61,122

c) Enabling Technologies for Integration (ETI PMO)

Effective January 31, 2014, the LHIN entered into an agreement with Erie St. Clair, Hamilton Niagara Haldimand Brant and Waterloo Wellington (the "Cluster") in order to enable the effective and efficient delivery of e-health programs and initiatives within the geographic area of the Cluster. Under the agreement, decisions related to the financial and operating activities of the Enabling Technologies for Integration Project Management Office are shared. No LHIN is in a position to exercise unilateral control.

3. Funding repayable to the MOHLTC and eHealth Ontario (continued)

c) Enabling Technologies for Integration (ETI PMO) (continued)

The South West LHIN is designated the Lead LHIN with this agreement and as such holds the accountability over the distribution of the funds and manages the shared Project Management Office. In the event that the Cluster experiences a surplus the Lead LHIN is responsible for returning those funds to the MOHLTC. The total Cluster funding received for the year ended March 31, 2017 was $2,040,000 (2016 - $2,040,000).

Funding of $ 1,530,000 (2016 - $1,530,000) was allocated to other LHIN's within the cluster who incurred eligible expenses of $1,530,000 (2016 - $1,530,000). The LHIN has setup a payable to the MOHLTC for $7,476.

The following provides condensed financial information for the ETI PMO funding and expenses for the cluster:

			2017	2016
	Funding allocated	Eligible expenses	Excess funding	Excess funding
	$	$	$	$
Erie St. Clair LHIN	510,000	510,000	-	-
Hamilton Niagara Haldimand Brant LHIN	510,000	510,000	-	-
Waterloo Wellington LHIN	510,000	510,000	-	-
South West LHIN	510,000	502,524	7,476	513
	2,040,000	2,032,524	7,476	513

4. Related party transactions

LHIN Shared Service Office,LHINC Collaborative and Health Shared Services Ontario

The LHIN Shared Services Office (the "LSSO") was a division of the Toronto Central LHIN and was subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs was responsible for providing services to all LHINs. The full costs of providing these services was billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN as at February 28, 2017 were recorded as a receivable (payable) from (to) the LSSO. This was done pursuant to the shared service agreement the LSSO has with all the LHINs.

The LHIN Collaborative (the "LHINC") was formed in fiscal 2010 to strengthen relationships between and among health service providers, associations and the LHINs, and to support system alignment. The purpose of LHINC was to support the LHINs in fostering engagement of the health service provider community in support of collaborative and successful integration of the health care system; their role as system manager; where appropriate, the consistent implementation of provincial strategy and initiatives; and the identification and dissemination of best practices. LHINC was a LHIN-led organization and accountable to the LHINs. LHINC was funded by the LHINs with support from the MOHLTC.

Effective February 28, 2017 pursuant to a transfer agreement between Toronto Central LHIN and Health Service Shared Services Ontario (HSSO) responsibility for the shared services previously provided by the LSSO and the LHINC was transferred to HSSO. HSSO is a provincial agency established January 1, 2017 by O. Reg. 456/16 made under LHSIA with objects to provide shared services to LHINs in areas that include human resources management, logistics, finance and administration and procurement. HSSO as a provincial agency is subject to legislation, policies and directives of the Government of Ontario and the Memorandum of Understanding between HSSO and the Minister of Health and Long Term Care.

4. Related party transactions (continued)

Patients First Pan-LHIN Support for Planning and Implementation

On June 13, 2016 an amendment to the Ministry-LHIN Accountability Agreement between Toronto Central LHIN and the Ministry resulted in an allocation of $1,080,000 of additional funding to be distributed by the Toronto Central LHIN to various LHINs to be applied to salary and benefit costs related to the support of transition and implementation of the expanded LHIN mandate. South West LHIN received $107,619 of this funding which was spent on eligible expenses in the year.

5. Deferred capital contributions

	2017	2016
	$	$
Balance, beginning of year	**43,594**	68,725
Capital contributions received during the year (Note 8)	**22,314**	7,695
Amortization for the year	**(21,618)**	(32,826)
Balance, end of year	**44,290**	43,594

6. Commitments

The LHIN has commitments under various operating leases extending to 2021 related to building and equipment which have standard renewal terms. Minimum lease payments due in each of the next five years are as follows:

	$
2018	346,723
2019	327,306
2020	327,114
2021	135,732
2022	77

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs, based on the current accountability agreements, are as follows:

	$
2018	2,286,516,565

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Tangible capital assets

	Cost	Accumulated amortization	2017 Net book value	2016 Net book value
	$	$	$	$
Computer equipment	242,202	232,370	9,832	25,708
Office equipment, furniture and fixtures	258,017	223,559	34,458	17,886
	500,219	455,929	44,290	43,594

8. Budget figures

The budget was approved by the Government of Ontario. The budget figures reported in the statement of operations reflect the initial budget at April 1, 2016. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $ 2,309,811,966 is derived as follows:

	$
Initial budget	2,249,599,783
Adjustment due to announcements made during the year	60,212,183
Final HSP funding budget	2,309,811,966

The final LHIN budget, excluding HSP funding, of $8,825,360 is derived as follows:

	$
Initial budget	8,583,366
Additional funding received during the year	264,308
Amount treated as capital contributions during the year	(22,314)
Final LHIN operating budget	8,825,360

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,309,811,966 to various HSPs in its geographic area. The LHIN approved transfer payments to various sectors in 2017 as follows:

	2017	2016
	$	$
Operation of hospitals	**1,574,467,090**	1,542,996,544
Grants to compensate for municipal taxation - public hospitals	**426,600**	426,600
Long term care homes	**339,024,414**	333,918,931
Community care access centres	**228,637,822**	219,536,498
Community support services	**47,829,870**	45,453,213
Assisted living services in supportive housing	**25,200,322**	23,913,885
Community health centres	**21,705,859**	21,557,702
Community mental health addictions program	**72,519,989**	71,037,461
	2,309,811,966	2,258,840,834

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2017, an amount of $ 7,656,700 (2016 - $13,455,322) was receivable from MOHLTC, and was payable to HSPs. These amounts have been reflected as revenue and expenses in the Statement of operations and are included in the table above.

10. Project Initiatives

The LHIN received funds for various initiatives listed in the Statement of Operations. The following table classifies the initiatives expenses by object:

	2017	2016
	$	$
Salaries and benefits	**1,772,305**	1,540,912
Professional services	**348,778**	332,541
Shared services	**10,067**	10,142
Occupancy	**77,033**	63,433
Public relations and community engagement	**-**	-
Supplies	**3,797**	3,846
Mail, courier and telecommunications	**10,534**	13,032
Other	**119,238**	175,359
	2,341,752	2,139,265

10. Project Initiatives (continued)

Diabetes Regional Coordination Centres

The MOHLTC provided the LHIN with $1,168,523 (2016 - $1,168,523) related to Diabetes Regional Coordination Centres initiatives. The LHIN incurred operating expenses of $1,157,016 (2016 - $1,168,343). The LHIN has setup a payable to the MOHLTC for the remaining balance of $11,507. Expenses incurred include the following:

	2017	2016
	$	$
Salaries	**1,047,781**	1,030,567
Operating expenses	**109,235**	137,776
Total	**1,157,016**	1,168,343

11. General and administrative expenses

The statement of operations presents the expenses by function; the following classifies general and administrative expenses by object:

	2017	2016
	$	$
Salaries and benefits	**3,524,261**	3,609,224
Occupancy	**261,899**	265,928
Amortization	**21,618**	32,826
Shared services	**325,506**	371,522
LHIN Collaborative	**52,714**	46,857
Public relations	**66,080**	68,182
Consulting and project expenses	**29,529**	44,766
Supplies	**15,170**	20,987
Board chair per diem	**61,089**	46,536
Board member per diem	**72,767**	74,271
Board member expenses	**76,323**	47,062
Mail, courier and telecommunications	**42,595**	43,255
Other	**313,227**	379,207
	4,862,778	5,050,623

12. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 44 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2017 was $415,822 (2016 - $387,615) for current service costs and is included as an expense in the statement of operations. The last annual funding valuation was completed for the plan as at December 31, 2015. As at that time, the plan was fully funded.

13. Guarantees

The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favor of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s.28 of the Financial Administration Act.

14. Subsequent event

On April 5, 2017 the Minister of Health and Long-Term Care made an order under the provisions of the Local Health System Integration Act, 2006, as amended by the Patients First Act, 2016 to require the transfer of all assets, liabilities, rights and obligations of the South West Community Care Access Centre the (CCAC), to the LHIN, including the transfer of all employess of the CCAC.

Effective May 24, 2017 the LHIN will assume the responsibility to provide health and related social services and supplies and equipment for the care of persons in home, community and other settings and to provide goods and services to assist caregivers in the provision of care for such persons, to manage the placement of persons into long-term care homes, supportive housing programs, chronic care and rehabilitation beds in hospitals, and other programs and places where community services are provided under the Home Care and Community Services Act, 1994 and to provide information to the public about, and make referrals to, health and social services.

ISSN 1911-2858 July/17 © 2017

Ontario

South West Local Health Integration Network